Filing at a Glance

Company:	The Lincoln National Life Insurance Company
Product Name:	ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL
State:	Arkansas
TOI:	L09I Individual Life - Flexible Premium Adjustable Life
Sub-TOI:	L09I.101 External Indexed - Single Life
Filing Type:	Form
Date Submitted:	09/24/2012
SERFF Tr Num:	LCNC-128655154
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	ABR-5762
Implementation Date Requested:	On Approval
Author(s):	Raymond Fortier, James Kane, Randi Johnson
Reviewer(s):	Linda Bird (primary)
Disposition Date:	10/01/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

General Information

Project Name: ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL
Project Number: ABR-5762
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: James Kane

Status of Filing in Domicile: Pending

Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 10/01/2012
State Status Changed: 10/01/2012
Created By: Randi Johnson
Corresponding Filing Tracking Number:

Filing Description:

Hon. Jay Bradford
Commissioner
Compliance-Life & Health
Attn: Joe Musgrove
1200 West Third Street
Little Rock, AR 72201-1904

Re.Individual Life Insurance Rider
ABR-5762 Accelerated Benefits Rider for Chronic Illness
The Lincoln National Life Insurance Company
Group & NAIC #: 020-65676

Dear Mr. Musgrove:

We are submitting the required number of copies of the above referenced rider for your review and approval. This is a new form and will not replace any previously approved form.

The Accelerated Benefits Rider for Chronic Illness is not intended to provide health, nursing home or long term care insurance. The rider is not intended to be a qualified long term care insurance contract under 7702B(b) of the Internal Revenue Code. The rider has been written to conform to the requirements of the Accelerated Death Benefit Regulations of your state, or, if your state has no such regulation, the NAIC Accelerated Benefits Model Regulation. The benefits paid under this rider are intended to be treated as accelerated death benefits under section 101(g)(1) of the Code.

The Accelerated Benefits Rider for Chronic Illness will be marketed through properly licensed agents in the general insurance market. This rider will be available for issue ages 20 to 80 and will be available for sex distinct and unisex issues. This rider provides for the advance payment of a portion of the death benefit, upon occurrence of a Qualifying Event provided all of the terms and conditions of this rider have been met. There are two Qualifying Events, as defined in the rider: (1) the Insured is certified as Chronically Ill; or (2) the Insured is certified as Terminally Ill. Chronic Illness benefits are available in either monthly payments or a one-time lump sum payment. If the Chronic Illness one-time lump sum is paid, the benefit will be reduced by an actuarial discount, and both the policy and this rider will terminate as noted in the rider's "Termination" provision. The Terminal Illness benefit is available in a lump sum that will be also be reduced by an actuarial discount however; the policy and rider will not terminate. There is no waiting period to receive a benefit under this rider and we do not require proof of incurred expenses for you to receive benefits under this rider. There are no restrictions on the use of the benefit payments.

A monthly cost of insurance charge for the rider will be deducted as part of the policy's monthly deduction. There is no administrative fee. Upon accelerated benefits being paid, the policy will not lapse as long as the rider is in force. For each policy month the policyowner receives a rider benefit payment, we will send the policyowner a monthly report showing the change in current values under the policy.

This rider is only available at issue. Upon approval, the rider may be used with previously approved individual flexible premium life insurance policies with optional indexed features and any individual flexible premium life insurance policies with optional indexed features, which may be approved in the future.

The following previously approved forms will be used to apply for the above-noted Accelerated Benefits Rider for Chronic Illness: Accelerated Benefits Rider for Chronic Illness Supplement LFF10249 previously approved on 6/27/2012 under file # LCNC-128289799; and application LFF06321_5-12, which was approved on 5/14/2012 under file # JEPL-128341108.

A copy of the Accelerated Benefits Rider for Chronic Illness Disclosure has been included as informational. At the time of application, the applicant will be provided with the Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10267) and the applicant and agent will both sign the disclosure. This disclosure is submitted for informational purposes only.

We have bracketed certain items in the forms as variable information because they may change for new issues in the future (but not in-force policies). These items include: officer names/signatures and the service office address, all factors, rates and charges. It is our understanding that changes to the bracketed items for new issues will not require a new filing of these forms. We confirm that the brackets will not actually appear on the forms at issue.

These forms appear in final printed format as issued from a laser printer. We do, however, use different computer publishing systems. It is therefore possible that actual issued forms may have a different font style than the submitted forms. As a result, page breaks may occur at different lines, line wording may not match up exactly, and the format may change.

This filing is being submitted concurrently to our Home State of Indiana and is pending approval. The rider achieves a Flesch score of 60.00. The policy form will be marketed with an illustration pursuant to the illustration regulation in your State and the corresponding certification is included. The appropriate certification(s), transmittal and filing fee are included, as applicable. To the best of our knowledge and belief, the filing complies with all the laws and regulations of your state.

We trust that the information provided is satisfactory and look forward to your response. Should you require any additional information, please feel free to contact me toll-free at 1-800-258-3648, ext. 5426, or via the fax number or email address shown below.

Sincerely,

James P. Kane

Senior Analyst, State Filing
E-mail: James.Kane@lfg.com
Fax: (603) 226-5128

Company and Contact

State: *Arkansas* ***Filing Company:*** *The Lincoln National Life Insurance Company*
TOI/Sub-TOI: *L09I Individual Life - Flexible Premium Adjustable Life/L09I.101 External Indexed - Single Life*
Product Name: *ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL*
Project Name/Number: *ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL/ABR-5762*

Filing Contact Information

James Kane, Analyst, Product Compliance
One Granite Place
Concord, NH 03301
james.kane@lfg.com
603-226-5426 [Phone]

Filing Company Information

The Lincoln National Life Insurance Company
350 Church Street - MPM1
Hartford, CT 06103-1106
(860) 466-2899 ext. [Phone]
CoCode: 65676
Group Code: 20
Group Name:
FEIN Number: 35-0472300
State of Domicile: Indiana
Company Type: Life
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation: One form at $50.00 per form.
Per Company: No

Company	Amount	Date Processed	Transaction #
The Lincoln National Life Insurance Company	$50.00	09/24/2012	62994992

SERFF Tracking #:	*LCNC-128655154*	***State Tracking #:***		***Company Tracking #:***	*ABR-5762*

State:	*Arkansas*	***Filing Company:***	*The Lincoln National Life Insurance Company*
TOI/Sub-TOI:	*L09I Individual Life - Flexible Premium Adjustable Life/L09I.101 External Indexed - Single Life*		
Product Name:	*ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL*		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/01/2012	10/01/2012

SERFF Tracking #:	*LCNC-128655154*	***State Tracking #:***		***Company Tracking #:***	*ABR-5762*

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Disposition

Disposition Date: 10/01/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Certificate of Compliance		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10267)		Yes
Form	Accelerated Benefits Rider for Chronic Illness		Yes

SERFF Tracking #:	*LCNC-128655154*	***State Tracking #:***		***Company Tracking #:***	*ABR-5762*

State:	*Arkansas*	***Filing Company:***	*The Lincoln National Life Insurance Company*
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Form Schedule

Lead Form Number: ABR-5762

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		ABR-5762	POLA	Accelerated Benefits Rider for Chronic Illness	Initial:	60.000	ABR-5762 GENERIC Bracketed.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

The Lincoln National Life Insurance Company

Service Office: [One Granite Place, P. O. Box 515, Concord, NH 03302-0515]

Accelerated Benefits Rider for Chronic Illness

(*Lincoln LifeEnhance*SM Accelerated Benefits Rider)

THE BENEFITS PAID UNDER THIS RIDER ARE INTENDED TO BE TREATED AS ACCELERATED DEATH BENEFITS UNDER SECTION 101(g)(1) OF THE INTERNAL REVENUE CODE OF 1986, AS AMENDED (THE "CODE"). THE COMPANY CONSIDERS THE BENEFITS PAID UNDER THIS RIDER THAT DO NOT EXCEED THE MAXIMUM PER DIEM LIMIT AS PRESCRIBED BY LAW TO BE ELIGIBLE FOR EXCLUSION FROM INCOME UNDER SECTION 101(a) OF THE CODE TO THE EXTENT THAT ALL APPLICABLE QUALIFICATION REQUIREMENTS UNDER THE CODE ARE MET. IF BENEFITS ARE PAID IN EXCESS OF THE APPLICABLE PER DIEM LIMIT, OR IF BENEFITS ARE PAID AND ALL APPLICABLE QUALIFICATION REQUIREMENTS ARE NOT MET, THE BENEFITS MAY CONSTITUTE TAXABLE INCOME TO THE RECIPIENT. THIS RIDER IS NOT INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER SECTION 7702B(b) OF THE CODE. THE TAX TREATMENT OF THE ACCELERATED DEATH BENEFITS MAY CHANGE, AND YOU SHOULD ALWAYS CONSULT AND RELY ON THE ADVICE OF A QUALIFIED TAX ADVISOR.

This rider is attached to and made a part of the Policy to which it is attached (the "Policy"). The effective date of this rider is the Policy Date. In this rider, "We", "Our" or "Us" means The Lincoln National Life Insurance Company; "You" and "Your" means the Owner of the Policy; and "Insured" means the person named in the Policy Specifications whose life is insured under the Policy.

This rider uses terms found in the Policy. Those terms have the same meaning as in the Policy unless We have indicated a change. The rider also contains terms that are not used in the Policy. Such terms may be defined within the sentences where they appear or they may be found in the "Definitions" section of this rider.

The Specified Amount, Policy Value, Cash Value, and Cash Surrender Value, if any, will be reduced if You receive accelerated death benefits under this rider as explained in the "Impact of Rider Benefits on Policy and Other Riders" provision.

The payment of a Chronic Illness one-time lump sum will cause termination of both this rider and the Policy in accordance with this rider's "Termination" provision.

Table of Contents

Definitions

Activities of Daily Living ("ADLs") The 6 basic functional abilities which measure the Insured's ability for self care and ability to live independently without Substantial Assistance from another individual. They are:

1. Bathing – The Insured's ability to wash himself or herself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. Continence – The Insured's ability to maintain control of bowel or bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. Dressing – The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Eating – The Insured's ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.
5. Toileting – The Insured's ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring – The Insured's ability to move into or out of a bed, chair or wheelchair.

Benefit Period A period of time not to exceed twelve consecutive months. Such period begins on the Monthly Anniversary Day after Our receipt of all documentation provided by You necessary to satisfy all Conditions for Eligibility for Benefit Payments. A new Benefit Period will begin no earlier than the end of the current Benefit Period.

Chronically Ill (Chronic Illness) The Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
2. Requiring Substantial Supervision from another individual to protect the Insured from threats to health and safety due to Severe Cognitive Impairment; AND
3. Needing Services pursuant to a Licensed Health Care Practitioner's Plan of Care as set forth in Written Certification or Written Re-certification, specifying such Services are likely to be needed for the rest of the Insured's life.

If the Licensed Health Care Practitioner certifies that the Insured will need Services for the rest of the Insured's life, the 90 day requirement noted in 1. above is satisfied by the expectation that the Insured will be unable to perform at least 2 Activities of Daily Living prospectively.

Cost Basis The aggregate amount of premiums or other consideration You have paid for the Policy, less the aggregate amount You have received under the contract that was not included in Your taxable income, and less reductions in values due to benefit payments under this rider as described in the "Impact of Rider Benefits on Policy and Other Riders" provision.

Gross Death Benefit Proceeds Death Benefit (as described in the Policy's "Death Benefit" provision) not reduced by any Debt as defined in the Policy.

Licensed Health Care Practitioner A physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury, or qualifications to Our satisfaction. The Licensed Health Care Practitioner (a) must be acting within the scope of his or her license in the state of licensure when providing Written Certification or Written Re-certification required by this rider; (b) may not be You, the Insured, or Your or the Insured's immediate family; and (c) must be licensed in the United States.

Maximum Monthly Benefit The maximum amount You are eligible to elect on a monthly basis.

Maximum Statutory Adjustable Policy Loan Interest Rate This maximum rate is determined as follows:

The rate will not be more than the higher of the following:

1. The published monthly average (defined below) for the calendar month ending 2 months before the date on which the rate is determined; or
2. The rate used to compute the Fixed Account under the Policy plus 1 percent.

The published monthly average referred to above is defined as:

1. Moody's Corporate Bond Yield Average - Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto; or
2. In the event that Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published, a substantially similar average, established by regulation, or other method, issued by the Insurance Department of the state or other jurisdiction where the Policy is delivered.

Monthly Benefit Amount If elected, the amount payable to You as a Chronic Illness benefit on a monthly basis, subject to the Maximum Monthly Benefit.

Plan of Care A written document signed by a Licensed Health Care Practitioner which outlines the individualized medical treatment and non-medical assistance and Services which are prescribed because the Insured suffers from loss of functional capacity or from a Severe Cognitive Impairment. The plan must specify where the care is to be provided; the type, frequency, and duration of all medication, therapy, and Services required. It must also describe the likelihood of improvement or deterioration of the Insured's condition within the next 12 months from the date the Plan of Care was prepared and must also describe the supporting evidence upon which the Licensed Health Care Practitioner has based his or her conclusions and prognosis. Such supporting evidence may include either documents or information relevant to the assessment of loss of functional capacity or to the assessment of Severe Cognitive Impairment, or both.

Per Diem Limit The maximum daily benefit used in determining the Chronic Illness Maximum Monthly Benefit. The Internal Revenue Service establishes this limit annually on January 1st. We will use the limit in effect at the beginning of each Benefit Period for the entire Benefit Period.

Remaining Benefit Amount The Original Benefit Amount less the amount of all Chronic Illness Monthly Benefit Amounts paid and, if applicable, less the Terminal Illness benefit paid divided by the applicable Terminal Illness actuarial discount factor.

Services The necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services needed by a Chronically Ill Insured.

Severe Cognitive Impairment Deterioration or loss in the Insured's intellectual capacity that is:

1. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
2. measured and confirmed by clinical evidence and standardized tests that reliably measure impairment in the following areas:
    a. the Insured's short-term or long-term memory;
    b. the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, month, and year); and
    c. the Insured's deductive or abstract reasoning, including judgment as it relates to safety awareness.

Substantial Assistance Hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

Substantial Supervision Continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to his or her health or safety (such as may result from wandering) due to Severe Cognitive Impairment.

Terminally Ill (Terminal Illness) The Insured's life expectancy is reduced to 12 months or less.

Terminally Ill (Terminal Illness) Certification Before any benefit can be paid for Terminal Illness, You must furnish evidence satisfactory to Us. Such evidence must include a certification of the Insured's medical condition from a Licensed Health Care Practitioner. The certification must state that in the Licensed Health Care Practitioner's opinion the Insured's life expectancy has been reduced to 12 months or less.

Written Certification Written documentation required in a form satisfactory to Us completed by a Licensed Health Care Practitioner, at Your or the Insured's expense, certifying that the Insured is Chronically Ill as defined herein, including a Plan of Care, and specifying that Services are likely to be needed for the rest of the Insured's Life.

Written Re-certification Written Certification that We must receive and approve prior to the start of each Benefit Period following the initial Benefit Period in order for You to be eligible for Chronic Illness Monthly Benefit Amounts in such subsequent Benefit Period, provided all other Conditions for Eligibility for Benefit Payments are met.

What This Rider Provides

This rider provides for the acceleration of up to 100% of the Original Benefit Amount, as determined below, upon occurrence of a Qualifying Event provided all of the terms and conditions of this rider have been met. There are two Qualifying Events, defined below: (1) the Insured is certified as Chronically Ill; or (2) the Insured is certified as Terminally Ill.

Depending on which Qualifying Event occurs and the benefit payment option You have chosen, the Original Benefit Amount will be determined as follows, assuming all the Conditions for Eligibility for Benefit Payments have been satisfied:

1. For Chronic Illness where You have elected in writing to receive benefits in a one-time lump sum as determined on the date all Conditions for Eligibility for Benefit Payments have been satisfied:

   The Policy's Gross Death Benefit Proceeds plus the death benefit of any Supplemental Term Insurance Rider on Primary Insured, if attached to the Policy and in force. Refer to the "Impact on Other Riders and Endorsements on the Policy" provision for details.

2. For Chronic Illness where You have elected in writing to receive Monthly Benefit Amounts and for Terminal Illness as determined on the Monthly Anniversary Day after Our receipt of all documentation provided by You necessary to satisfy all Conditions for Eligibility for Benefit Payments:

   The Policy's Gross Death Benefit Proceeds after change to Death Benefit Option I plus the death benefit of any Supplemental Term Insurance Rider on Primary Insured, if attached to the Policy and in force. Refer to the "Impact on Other Riders and Endorsements on the Policy" provision for details.

There is no waiting period to receive a benefit under this rider once all Conditions for Eligibility for Benefit Payments have been satisfied and benefits will be paid retroactively to the date of Our receipt of all documentation provided by You that is necessary to satisfy all Conditions for Eligibility for Benefit Payments. Furthermore, We do not require proof of incurred expenses for You to receive benefits under this rider. This rider's benefits will only be paid to the Owner of the Policy and will only be paid by check or other method made available by Us. Any benefit paid during the Policy's Contestable Period is subject to the "Incontestability" provision of the Policy.

Your Benefit Payment Options

(1) **For a Chronic Illness Qualifying Event**

You may elect in writing to receive the benefit as either (a) Monthly Benefit Amounts or (b) a one-time lump sum payment.

(a) **Monthly Benefit Amounts** - Provided all Conditions for Eligibility for Benefit Payments have been satisfied, You may elect to receive accelerated monthly benefit payments (the "Monthly Benefit Amount") without losing the option of electing a one-time lump sum payment of the Remaining Benefit Amount.

For each Benefit Period in which You qualify to receive benefits, You may elect in writing a Monthly Benefit Amount equal to or greater than the Minimum Monthly Benefit but not exceeding the Maximum Monthly Benefit. Both the Minimum Monthly Benefit and the Maximum Monthly Benefit are shown on the Policy Specifications. Please note that the Monthly Benefit Amount is not cumulative. The entire Maximum Monthly Benefit may be taken, but if not, the remaining portion cannot be added to future payments. By electing a Monthly Benefit Amount less than the Maximum Monthly Benefit, the amount of the Original Benefit Amount available for later benefit payments (the "Remaining Benefit Amount") will be reduced more slowly; however, You should consider that You may or may not re-qualify for future Written Re-certifications.

The largest amount that may be elected is the Maximum Monthly Benefit. As shown on the Policy Specifications, the Maximum Monthly Benefit may not exceed the lesser of the percentage of the Original Benefit Amount or the monthly equivalent of the Per Diem Limit (see "Definitions" above). At the time of claim and for each subsequent Benefit Period, defined above, We will notify You of Your Maximum Monthly Benefit.

Sixty (60) days prior to the end of each Benefit Period, We will send You documentation for Written Re-certification. As part of this documentation, if Your Maximum Monthly Benefit is based on the Per Diem Limit and the Per Diem Limit increases, We will provide You with an adjusted Maximum Monthly Benefit. If Your Maximum Monthly Benefit is based on the Per Diem Limit, the Maximum Monthly Benefit in this documentation will be based on a 30 day policy month. If You elect the Maximum Monthly Benefit, the actual amount You receive will be adjusted based on the number of days in each policy month. To minimize a possible delay or interruption in Your Chronic Illness Monthly Benefit Amount payments, provide Your Written Re-certification within the requested timeframe.

(b) **One-Time Lump Sum** - If You elect a one-time lump sum payment, the Remaining Benefit Amount will be multiplied by the applicable Chronic Illness one-time lump sum actuarial discount factor when determining the amount of the payment (as described in the "Actuarial Discount Factors" provision). **The payment of a one-time lump sum will cause termination of both this rider and the Policy in accordance with this rider's "Termination" provision.**

(2) **For a Terminal Illness Qualifying Event**

The maximum Terminal Illness benefit payment will be the lesser of: 1) 50% of the Remaining Benefit Amount; or 2) $250,000. **Note: This benefit will only be paid once and will be paid as a lump sum. If You elect in writing less than the maximum benefit, the remainder will not be available at a later date.** The amount accelerated will be greater than the Terminal Illness benefit payment and will be determined by dividing the requested benefit payment by the applicable Terminal Illness actuarial discount factor (as described in the "Actuarial Discount Factors" provision). The amount accelerated will not be allowed to exceed the Remaining Benefit Amount.

Subject to meeting all Conditions for Eligibility for Benefit Payments, You may elect to receive accelerated benefits under multiple Qualifying Events and multiple benefit payment options as follows:

1. Chronic Illness in Monthly Benefit Amounts and then at a later date elect the Chronic Illness one-time lump sum payment; or
2. Chronic Illness Monthly Benefit Amounts and then at a later date elect to receive the Terminal Illness benefit. In the same policy month, You may receive both a Chronic Illness Monthly Benefit Amount and the Terminal Illness benefit; or
3. Chronic Illness Monthly Benefit Amounts, then at a later date elect to receive the Terminal Illness benefit and finally receive the Chronic Illness one-time lump sum payment; or
4. Terminal Illness benefit and then at a later date elect to receive a Chronic Illness benefit in either Monthly Benefit Amounts or the one-time lump sum payment, or both.

Actuarial Discount Factors

A Chronic Illness one-time lump sum actuarial discount factor will be applied to the Chronic Illness one-time lump sum and a Terminal Illness actuarial discount factor will be applied to the Terminal Illness amount accelerated. This actuarial discount factor reflects the early payment of benefits available under the Policy. The actuarial discount factor used will be based on a mortality assumption and an interest rate which has been declared by Us in effect on the date the benefit payment is determined. The maximum interest rate used shall not exceed the greater of:

1) the current yield on 90 day treasury bills available on the date the benefit payment is determined; or

2) the current Maximum Statutory Adjustable Policy Loan Interest Rate in effect on the date the benefit payment is determined.

When Benefit Payments Begin and End

Any benefit payable under an option chosen by You will be paid to You no later than the first Monthly Anniversary Day following the date We approve all documentation necessary to satisfy all Conditions for Eligibility for Benefit Payments. Provided all of the Conditions for Eligibility for Benefit Payments are met and during any Benefit Period, any subsequent Chronic Illness Monthly Benefit Amounts will be payable on each Monthly Anniversary Day following the date of the first Monthly Benefit Amount payment. We will pay a proportionate amount of the Monthly Benefit Amount for the number of days between the date of Our receipt of all documentation necessary to satisfy all Conditions for Eligibility for Benefit Payments and the start of the Benefit Period.

Chronic Illness Monthly Benefit Amounts will end when any of the following occur:

(1) the Insured fails to meet any one of the Conditions for Eligibility for Benefit Payments;

(2) You notify Us to discontinue Monthly Benefit Amount payments;

(3) the Remaining Benefit Amount is reduced to zero; or

(4) this rider terminates.

In the event You Request that We discontinue Monthly Benefit Amount payments and then, at a later date, You desire to begin a new Benefit Period, We will allow You to do so provided all of the Conditions for Eligibility for Benefit Payments are met.

Conditions for Eligibility for Benefit Payments

You are eligible to receive an accelerated benefit payment if the Policy and this rider are in force when all of the following requirements are met:

1. Our receipt and approval of the following documentation provided by You:
   a. Certification of either:
      i. For Chronic Illness, Written Certification or Written Re-certification by a Licensed Health Care Practitioner that the Insured is a Chronically Ill individual; or
      ii. For Terminal Illness, Terminally Ill Certification by a Licensed Health Care Practitioner that the Insured is Terminally Ill.
   b. Our receipt of consent to make such payment, in writing, of any assignee of record named under the Policy or any Irrevocable Beneficiary named under the Policy.
2. We complete, at Our discretion and expense, a personal interview with, and an assessment of, the Insured, including examination or tests by a Licensed Health Care Practitioner of Our choice; and Our receipt of copies of any relevant medical records from a health care provider involved in the Insured's care; and
3. The Insured is living at the time all of the above requirements are met.

Reduction in Benefit Payment Due to Debt

Any Chronic Illness Monthly Benefit Amount or Terminal Illness benefit paid under this rider will be first used to repay a portion of any outstanding Debt under the Policy. The portion to be repaid will be determined by the product of the following:

[A / B] * C where:

A. is Debt;

B. is the Remaining Benefit Amount immediately prior to a benefit payment; and

C. is either i. or ii. noted below depending on the Qualifying Event:

   i. the Chronic Illness Monthly Benefit Amount; or

   ii. the Terminal Illness benefit payment divided by the applicable Terminal Illness actuarial discount factor.

If the Chronic Illness one-time lump sum benefit payment is elected, the benefit payment will be reduced by any outstanding Debt under the Policy.

Impact on Other Riders and Endorsements on the Policy

If any of the following riders or endorsements are attached to Your Policy, this rider may have an impact on any benefits provided under such rider or endorsement.

Supplemental Term Insurance Rider on Primary Insured: The death benefit of any in force Supplemental Term Insurance Rider on Primary Insured will be included in the calculation of the Original Benefit Amount.

Accidental Death Benefit Rider: The Insured's accidental death benefit will not be affected by the acceleration of benefits.

Disability Waiver of Monthly Deduction Benefit Rider: If You are on total disability as provided under any Disability Waiver of Monthly Deduction Benefit Rider, We will continue to waive the monthly deductions falling due under the Policy once payment of an accelerated benefit begins under this rider.

Children's Term Insurance Rider: If this rider terminates due to the receipt of a Chronic Illness one-time lump sum payment or the Remaining Benefit Amount is reduced to zero, the Children's Term Insurance Rider's benefit will be paid as paid-up insurance as described in the rider's "Non-forfeiture Values" provision.

Overloan Protection Endorsement: If Your Policy has a loan and You have received either a Chronic Illness Monthly Benefit Amount or a Terminal Illness benefit, the "Minimum Death Benefit" provision of this rider will supercede the Overloan Protection Endorsement. If this rider terminates and the Policy remains in force, the "Overloan Protection Feature" of the Overloan Protection Endorsement will be available subject to the terms of the endorsement.

Impact of Rider Benefits on Policy and Other Riders

Benefit payments under this rider will reduce certain policy and rider values by multiplying such values by a Reduction Ratio noted below. The values that will be reduced are as follows:

1. Specified Amount;
2. The death benefit of any Supplemental Term Insurance Rider on Primary Insured, if attached to the Policy.
3. Policy Value. The Reduction Ratio will be applied to the Policy Value; the Fixed Account Value will be reduced first. If insufficient value exists in the Fixed Account to cover the reduction in Policy Value, the most recently opened Segment in the Indexed Account(s) will be reduced and will continue in successive order on a last in – first out basis. If multiple Segments were opened on the same Allocation Date, a prorated portion will be taken from each Segment. If insufficient value exists in the Fixed Account and Indexed Account(s) Segment(s), the Collateral Account (as defined in the Fixed Loan Endorsement) will be reduced;
4. Your "Cost Basis" in the Policy, see "Definitions" above; and
5. Premiums paid to date.

Any reduction will occur on the Monthly Anniversary Day prior to the monthly deduction. The proportion by which the above values will be reduced will be based on a Reduction Ratio, determined as follows:

1. **Chronic Illness Benefit Payments:**

   Each Monthly Benefit Amount will reduce the above values by a Reduction Ratio of (b-a)/b where:

   a. is the Monthly Benefit Amount, and

   b. is the Remaining Benefit Amount immediately prior to a benefit payment.

2. **Terminal Illness Benefit Payment:**

   The payment of a Terminal Illness benefit will reduce the above values by a Reduction Ratio of (b-a)/b where:

   a. is the Terminal Illness benefit payment divided by the applicable Terminal Illness actuarial discount factor, and

   b. is the Remaining Benefit Amount immediately prior to the benefit payment.

If a Death Benefit Option other than Death Benefit Option I is in effect, the Death Benefit Option will be changed to Death Benefit Option I prior to the first benefit payment. No further Death Benefit Option changes are permitted.

If there is any premium in a premium deposit fund, this premium will be returned to You and will be treated as a normal return of premium and not as a benefit payment under this rider. If We return any accrued interest with the premium amount, the interest will be reported as taxable income to You.

The remainder of the provision only applies if You have received an accelerated benefit payment:

Debt will be reduced as noted in the "Reduction in Benefit Payment Due to Debt" provision.

For each policy month You receive a rider benefit payment, We will send You a monthly report showing the change in current values under Your Policy.

The Surrender Charges as shown on the Policy Specifications will be waived.

If the "10 Year Minimum Premium" provision is in effect, the provision will terminate.

You may not make a change in Specified Amount, a change in the Insured's Rate Class as shown on this rider's Policy Specifications, or add rider benefits or increase the amount of rider benefits.

If there is an existing Participating Loan on Your Policy, the loan will be converted to a Fixed Loan subject to the Fixed Loan Endorsement. The loan conversion limitation of once per twelve-month period will not apply.

Further, We reserve the right to transfer all value of each and every Indexed Account Segment to the Fixed Account.

If the death of the Insured occurs while benefits are being received under this rider, We will pay the Death Benefit, which may be less than the Remaining Benefit Amount, and the Death Benefit will be reduced by any decrease in the Remaining Benefit Amount after the date of the Insured's death.

If the Supplemental Term Insurance Rider on Primary Insured terminates in accordance with the rider's "Termination" provision, the rider's death benefit will not be payable upon the death of the Insured. However, the rider's death benefit will remain as part of the Remaining Benefit Amount.

Minimum Death Benefit

If Your Policy has a loan and You have received either a Chronic Illness Monthly Benefit Amount or a Terminal Illness benefit, notwithstanding any provision to the contrary contained in the Policy, the death benefit of the Policy will equal the greater of 1) or 2), where:

1) is the Death Benefit as described in the "Death Benefit" provision of the Policy; and

2) is a minimum death benefit of $10,000.

If Your Policy has a loan, You have received either a Chronic Illness Monthly Benefit Amount or a Terminal Illness benefit, and this provision's item 2) has been invoked, this rider and the Policy will not terminate in accordance with this rider's "Termination" provision item 4.

If this rider terminates and the Policy remains in force, the "Overloan Protection Feature" of the Overloan Protection Endorsement will be available subject to the terms of the endorsement.

Cost of Insurance

This rider's cost of insurance will be part of the monthly deduction made under the Policy. The amount deducted each policy month will be calculated as (A) multiplied by (B) where:

(A) is the applicable rate found in the "Guaranteed Cost of Insurance Rate Per $1,000 of Policy Net Amount at Risk or Rider Net Amount At Risk" table of rates shown on the Policy Specifications; and (B) is either i. or ii. noted below:

i. For any policy month prior to acceleration of the death benefit, the Policy's net amount at risk plus the death benefit of any in force Supplemental Term Insurance Rider on Primary Insured divided by $1,000; or

ii. Following acceleration of the death benefit, for any policy month in which benefits are not payable, this rider's net amount at risk divided by $1,000.

This rider's net amount at risk is equal to the Remaining Benefit Amount at the beginning of the policy month, discounted to the beginning of the month at the guaranteed interest rate noted on the Policy Specifications page, minus the Policy Value at the beginning of the policy month.

Each policy month You receive a Chronic Illness Monthly Benefit Amount or the Terminal Illness benefit, this rider's cost of insurance will be waived.

Waiver of Monthly Deductions

Once benefit payments begin, the Policy will not terminate according to the Policy's "Grace Period" provision as long as this rider is in force. The Policy's monthly deductions will continue unless the Policy Value less Debt is insufficient to cover the monthly deduction. We will stop billing You and will not allow premium payments unless otherwise agreed to by You and Us. However, We will continue to accept loan repayments.

General Provisions

Exclusions

This rider does not provide an accelerated benefit for Chronic Illness resulting from:

1. Intentionally self-inflicted injury or attempted suicide, while sane or insane;
2. Any act or incident of insurrection or war, declared or undeclared;
3. The Insured's participation in, or attempting to participate in, a felony, riot, or insurrection; or
4. Alcoholism or drug addiction.

In addition, this rider does not provide a benefit if the Insured's Licensed Health Care Practitioner is: (a) You, the Insured, or Your or the Insured's immediate family; or (b) not licensed in the United States.

Reinstatement

You may reinstate this rider as part of Your Policy if the Policy is terminated and reinstated. Such reinstatement will be subject to satisfactory evidence of insurability and all other terms and conditions of the Policy.

Rider Termination

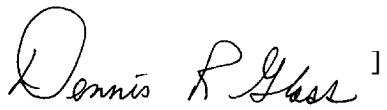
This rider and all rights provided under it will terminate automatically upon whichever of the following occurs first:

1. The date We receive Your Request to terminate this rider;
2. The Policy's Specified Amount plus the death benefit of any Supplemental Term Insurance Rider on Primary Insured, if attached to the Policy and in force, exceeds the Specified Amount Limit in effect as shown on the Policy Specifications;
3. The receipt of a Chronic Illness one-time lump sum payment which will cause the termination of both this rider and the Policy;
4. The Remaining Benefit Amount is reduced to zero which will cause the termination of both this rider and the Policy;

5. Termination of the Policy; or
6. The death of the Insured which will cause the Death Benefit to become payable under the Policy.

In addition, if You have received an accelerated benefit payment, this rider will terminate on the earliest of the following:

1. The date You take a partial surrender under the Policy; or
2. The date You take a loan under the Policy.

[]

[President]

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Readability_UL_Term.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	Please refer to a specimen copy of previously approved application LFF06321_5-12, which was approved on 5/14/2012 under file # JEPL-128341108.		
Attachment(s):			
LFF06321_5-12 Application Specimen.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Certificate of Compliance		
Comments:			
Attachment(s):			
AR Cert. of Compliance_UL_VUL_Term.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10267)		
Comments:	A copy of the Accelerated Benefits Rider for Chronic Illness Disclosure has been included as informational. At the time of application, the applicant will be provided with the Accelerated Benefits Rider for Chronic Illness Disclosure (form LFF10267) and the applicant and agent will both sign the disclosure. This disclosure is submitted for informational purposes only.		
Attachment(s):			
LFF10267 Application Disclosure GENERIC Bracketed.pdf			

Arkansas

READABILITY CERTIFICATION

The Lincoln National Life Insurance Company

Re: ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

Form Number:	***Flesch:***
ABR-5762	***60***

Raymond Fortier, Assistant Vice President
Product Compliance & State Filing

Date: September 11, 2012

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to each Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year contestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901]. [(TTY {866} 346-3642)]

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APPLICATION FOR LIFE INSURANCE - PART I

APPLICANT INFORMATION - PROPOSED INSURED A (Required Section)

1. Proposed Insured A *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age [70], please complete Section D.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM

COVERAGE INFORMATION *(As available per product)*

18. Plan of Insurance _____ 19. Amount of Insurance $ _____ *(Specified Amount, if UL or VUL)*

20. (i) Death Benefit Option *(Complete for Universal Life and Variable Universal Life Product only - not required for Term or Whole Life.)*
☐ Level ☐ Increase by Cash Value ☐ Increase by Premium ☐ Increase by Premium Less Policy Factor

(ii) Death Benefit Qualification Test (DBQT) - For IRS purposes, premiums will be tested using the Guideline Premium Test unless ☐ Cash Value Accumulation Test is checked (not available on all products or with all riders).
The DBQT cannot be changed after issue unless the terms of the policy require a change.

21. Save Age? ☐ Y ☐ N *(If not saving age, policy will be current dated.)*

22. Additional Benefits and Riders: *(If applicable)*

☐ Supplemental Coverage $ _____
☐ Term on Spouse/Other Insured Rider $ _____ *(Please complete Section B - Applicant Information - Proposed Insured B)*
☐ Accelerated Benefit Rider
☐ Waiver of Premium
☐ Waiver of Monthly Deductions
☐ Waiver of Specified Premium $ _____
☐ Children's Term Insurance Rider *(Complete Child's Supplement)*

☐ Other Benefits and Riders *(not listed above)*. (Please provide full details: e.g. coverage amounts/percentages/etc.):

BILLING INSTRUCTIONS *(As available per product)*

23. Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT) ☐ Other _____

24. Modal Planned Premium: $ _____ 25. Lump Sum: $ _____ ☐ 1035 Exchange

26. Special Billing: *(check one, if applicable)* ☐ New List Bill ☐ Existing List Bill Number: _____

27. Source of Premium: _____ *(inheritance, loan, business activity)* 28. Automatic Premium Loan: ☐ Y ☐ N *(Complete for Whole Life only.)*

29. Premium Notices To: *(check one only.)* *(Please note we cannot bill to your agent.)*
☐ Owner in Question 31 ☐ Owner in Question 37 ☐ Insured at Business ☐ Insured at Residence ☐ Other *(indicate below)*

30. Special Instructions:

OWNER INFORMATION *(If left blank, Proposed Insured(s) will be owner)*

31. Owner Name	
32. Owner Address	
33. Relationship to Proposed Insured(s)	34. Owner Soc. Sec. No. / TIN
35. Date of Birth/Trust Date	36. Citizen of (Country)
37. Owner Name	
38. Owner Address	
39. Relationship to Proposed Insured(s)	40. Owner Soc. Sec. No. / TIN
41. Date of Birth/Trust Date	42. Citizen of (Country)

43. Is this policy being purchased as part of an employer owned life insurance program where the employer is the direct or indirect beneficiary of the policy? ☐ Y ☐ N

BENEFICIARY DESIGNATION (*Unless otherwise stated below, if multiple beneficiaries are named in a class (Primary, Contingent), the proceeds are to be paid equally to the survivor or survivors, if any, in the class.)*

Select Primary (P) or Contingent (C) Beneficiary for each line completed. If Trust, check here ☐.

44. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
45. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
46. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
47. ☐ P ☐ C	a. Name/Trust name & Trustees	b. Soc. Sec. No./TIN c. Relationship to Proposed Insured
48.	Special Instructions	

APPLICANT INFORMATION - PROPOSED INSURED A

49. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes", please complete and sign all required replacement forms.)

50. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	

51. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐Y ☐N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		

52. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

53. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐Y ☐N

54. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐Y ☐N

GENERAL RISK INFORMATION - PROPOSED INSURED A

55. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* ☐Y ☐N

56. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* ☐Y ☐N

57. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* ☐Y ☐N

58. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in the "Details" space provided.)* ☐Y ☐N

59. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in the "Details" space provided.)* ☐Y ☐N

60. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)* ☐Y ☐N

61. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐Y ☐N

Type:	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED A *(Answer this section only when required.)*

62. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

63. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐Y ☐N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

64.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

65. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

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SECTION A - HEALTH SUMMARY

APPLICANT INFORMATION - PROPOSED INSURED A

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured A *(First, Middle, Last)*	2. Date of Birth *(mm/dd/yy)*

► **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	Yes	No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
5. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
7. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

11. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

SECTION B - ADDITIONAL INSURED

APPLICANT INFORMATION - PROPOSED INSURED B

1. Proposed Insured B *(First, Middle, Last)*		2. ☐ Male ☐ Female
3. Date of Birth (If over age [70] please complete Section D.) *(mm/dd/yy)*	4. Soc. Sec. No.	5. Are you a citizen of the United States? ☐ Y ☐ N If "No," what country?
6. Place of Birth *(State, Country)*	7. Driver's License # & State	
8. Home Address *(Street, City, State, ZIP)*		
9. Occupation/Duties	10. Employer	
11. Business Address *(Street, City, State, ZIP)*		
12. Annual Earned Income $	13. Annual Unearned Income $	14. Net Worth $
15. In the last 5 years have you filed for bankruptcy? ☐ Y ☐ N *(If "Yes," please complete the Financial Supplement.)*	16. Primary Phone # ☐ AM ☐ PM	17. Work Phone # ☐ AM ☐ PM

18. Beneficiary for applicable Rider: a. Name	
b. Soc Sec. No./TIN	c. Relationship to Proposed Insured B

19. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefits under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Y ☐ N
(If "Yes", please complete and sign all required replacement forms.)

20. Please list amounts of all inforce life insurance on your life, including any policies that have been sold. *(Please list in the box below.)*
If none, check this box: ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	
	$			☐ Y ☐ N	☐ Y ☐ N	

21. Do you have any applications currently pending or do you plan to apply for new life or disability insurance coverage with any other company? *(If "Yes," please provide details in the space provided.)* ☐ Y ☐ N

Company	Amount	Type (Life or Disability)	Reason Policy Applied For
	$		
	$		

22. What is the total amount of new life insurance coverage that will be placed inforce with all companies including this application? $_____

23. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Supplement.)* ☐ Y ☐ N

24. Have you ever applied for life, health or disability insurance and been declined, postponed or charged an increased premium? *(If "Yes", provide further information in the "Details" space provided.)* ☐ Y ☐ N

GENERAL RISK INFORMATION - PROPOSED INSURED B

25. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)* ☐ Y ☐ N

26. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)* ☐ Y ☐ N

27. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)* ☐ Y ☐ N

28. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, restricted or revoked? *(If "Yes," please indicate what type and dates in space provided below.)* ☐ Y ☐ N

29. Have you ever been convicted of or are you awaiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole, in space provided below.)* ☐ Y ☐ N

30. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; on the space provided below.)* ☐ Y ☐ N

31. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)* ☐ Y ☐ N

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

MEDICAL INFORMATION - PROPOSED INSURED B *(Answer this section only when required.)*

32. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

a. Date and reason of last visit:

b. Tests performed & treatment received:

33. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N

Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

34.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

35. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

Lincoln Financial Group℠

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SECTION C - HEALTH SUMMARY

APPLICANT INFORMATION PROPOSED INSURED B

(Complete if not submitting a Medical Supplement - Part II of Application or to initiate underwriting process. See Underwriting Guidelines for further details.)

1. Proposed Insured B *(First, Middle, Last):*	2. Date of Birth *(mm/dd/yy)*:

► **If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided.**

	Yes	No
3. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
4. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐
5. **Have you ever had any indication of, or been treated by a licensed medical professional for:**		
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c. Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder or medically or surgically treated condition not listed above?	☐	☐
6. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
7. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*	☐	☐
Type _____ Frequency_____ Amount _____		
8. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
9. In the past 5 years have you used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐

10. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements.

11. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*

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SECTION D - DEFINED AGE QUESTIONNAIRE
(Complete if either Proposed Insured is age [70] or over.)

1. Proposed Insured A *(First, Middle, Last)* _____

2. Proposed Insured B *(First, Middle, Last)* _____

	Proposed Insured A	Proposed Insured B
3. Will you, the proposed insured and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N	☐Y ☐N
4. Have you, the proposed insured, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf which will have an ownership or beneficial interest in this policy?	☐Y ☐N	☐Y ☐N
5. Have you, the proposed insured, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the proposed insured, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N	☐Y ☐N
6. Have you, the proposed insured, ever sold a policy to a life settlement, viatical or other secondary market provider, or are you in the process of selling a policy?	☐Y ☐N	☐Y ☐N
7. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*		

OWNER INFORMATION

8. Owner Name _____	Owner
9. Will you, the proposed owner and/or beneficiary, and/or any entity on your behalf, receive any compensation as an inducement to purchase the policy, whether via the form of cash, property, an agreement to receive money in the future, or otherwise, if this policy is issued?	☐Y ☐N
10. Have you, the proposed owner, been involved in any discussion about the possible sale or assignment of this policy to an unrelated third party, as an inducement to purchase the life insurance policy? Have you been involved in any discussion about the possible sale or assignment of a beneficial interest in a trust, limited liability company or other entity created or to be created on your behalf?	☐Y ☐N
11. Have you, the owner, been involved in any discussion about the projected value of this policy in a future sale to an unrelated third party? Do you, the owner, understand that estimated values of policies in the life settlement or other secondary marketplace are not guaranteed and that you may not be able to sell your policy for any amount in excess of the cash surrender value?	☐Y ☐N
12. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? *(If "Yes", please complete the Premium Financing Application Supplement.)*	☐Y ☐N
13. **Details:** *(List details from questions answered "Yes" and please specify to which question numbers details pertain.)*	

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

SUITABILITY

Complete only if applying for Variable Life Insurance and submit allocation form(s) with this Application:

1. Have you, the Proposed Insured(s) and the Owner, if other than the Proposed Insured(s), received a current Prospectus for the policy applied for and have you had sufficient time to review it?	☐ Y ☐ N
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Y ☐ N
3. Do you understand that the cash values may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Y ☐ N
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Y ☐ N

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

AGREEMENT AND ACKNOWLEDGEMENT

I, the Owner, certify that the tax identification or social security number as provided by me is correct. I also certify that I am not subject to backup withholding.

Each of the Undersigned declares that:

1. This Application consists of: a) Part I (including Sections A-D if needed); b) Part II Medical Application, if required; c) any amendments to the application(s) attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I shall be complete when it includes Applicant Information - Proposed Insured A, and any or none of the following (please check, as applicable, included Sections A-D):
   ☐ Section A- Health Summary -Proposed Insured A, ☐ Section B- Applicant Information -Proposed Insured B,
   ☐ Section C -Health Summary -Proposed Insured B, and ☐ Section D - Defined Age Questionnaire.
2. I/We further agree that (except as provided in the Temporary Life Insurance Agreement if advance payment has been made and acknowledged below and such Agreement issued), insurance will take effect under the Policy only when: 1) the Policy has been delivered to and accepted by me/us; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured(s); and 3) the Proposed Insured(s) remain in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.

   I/We have paid $ _____ to the Agent/Representative **in exchange for the Temporary Life Insurance Agreement**, and I/we acknowledge that I/we fully understand and accept its terms. *(Please complete Temporary Life Insurance Agreement and submit with application.)*
3. No agent, broker or medical examiner has the authority to make or modify any Company contract or to waive any of the Company's requirements.
4. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing below. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
5. For employer owned life insurance policies, the owner hereby acknowledges its sole responsibility for ensuring that it complies with all legal and regulatory requirements related to life insurance it purchases on its employees, including appropriate disclosure to each employee whose life is insured under such a life insurance policy.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURES

All jurisdictions except AR, AZ, CT, DC, FL, KS, KY, LA, ME, MN, NJ, NM, OH, OK, PA, TX, VA and WA. Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AR, DC, KY, ME, NM, OH and PA Only. Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me/us or my/our physical or mental health or insurability to disclose that information to the Company, its reinsurers, or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

Signature of Proposed Insured A
(Parent or Guardian if under 14 years of age)

Signature of Proposed Insured B (If coverage applied for)
(Parent or Guardian if under 14 years of age)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

Signature of Applicant/Owner/Trustee (If other than Proposed Insured)
(Provide Officer's Title if policy is owned by a Corporation)

TO BE COMPLETED BY AGENT ONLY

(i) Does the applicant have any existing life insurance policies or annuities? ☐ Y ☐ N

(ii) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Y ☐ N
If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Licensed Agent, Broker or Registered Representative

Name of Licensed Agent, Broker or Registered Representative
(Please Print)

APPLICABLE TO VARIABLE LIFE ONLY

I have reviewed the Application, Supplements, New Account Form and allocation forms and find the transaction suitable.

Signature of Registered Principal of Broker/Dealer

Name of Registered Principal of Broker/Dealer (Please Print)

ARKANSAS

CERTIFICATE OF COMPLIANCE

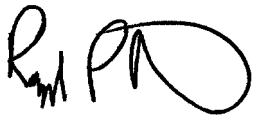
The Lincoln National Life Insurance Company

Re: ABR-5762 Accelerated Benefits Rider for Chronic Illness IUL

To the best of my knowledge and belief, the policy form listed above complies with the provisions of Rule and Regulation 19 as well as all applicable requirements of the Arkansas Insurance department.

To the best of my knowledge and belief we are in compliance with the requirements of Arkansas Code Ann. 23-79-138. We provide a document entitled which contains the required information.

To the best of my knowledge and belief we are in compliance with the requirements of Regulation 49 and we provide the required Guaranty Association notice.



Raymond Fortier, Assistant Vice President
Product Compliance & State Filing

Date: September 11, 2012

VUL, UL

The Lincoln National Life Insurance Company
Service Office: [PO Box 21008, Greensboro, NC 27420-1008]
(hereinafter referred to as "the Company")

ACCELERATED BENEFIT RIDER FOR CHRONIC ILLNESS DISCLOSURE

Lincoln LifeEnhance^{SM} Accelerated Benefits Rider

This Disclosure provides a summary of the important features of this rider. It does not alter any of the rider's provisions. Eligibility and receipt of benefits provided by the rider will be governed in full by the actual terms and provisions set forth in the rider. Benefits may be taxable as income and assistance should be sought from a personal tax advisor. Benefits are not subject to approval of receipts for reimbursement and there is no waiting period. Receipt of an accelerated death benefit payment may adversely affect your eligibility for Medicaid or other government benefits and entitlements.

TAX QUALIFICATION

The benefits paid under this rider are intended to be treated as accelerated death benefits under section 101(g)(1) of the Internal Revenue Code of 1986, as amended (the "Code"). The Company considers the benefits paid under this rider that do not exceed the maximum Per Diem Limit as prescribed by law to be eligible for exclusion from income under section 101(a) of the Code to the extent that all applicable qualification requirements under the Code are met. If benefits are paid in excess of the applicable Per Diem Limit, or if benefits are paid and all applicable qualification requirements are not met, the benefits may constitute taxable income to the recipient. This rider is not intended to be a qualified long-term care insurance contract under section 7702B(b) of the Code. The tax treatment of the accelerated death benefits may change, and you should always consult and rely on the advice of a qualified tax advisor.

1. What is an accelerated benefit?

- An accelerated death benefit is all or a portion of the policy's death benefit that we will pay in advance when (a) the Insured has been certified by a Licensed Health Care Practitioner as being Chronically Ill or (b) the Insured has been certified by a Licensed Health Care Practitioner as Terminally Ill AND
- all of the Conditions for Eligibility for Benefit Payments have been satisfied.

2. When am I eligible for Benefit Payments?

- You are eligible to receive a benefit if the policy and rider are in force when all the Conditions for Eligibility for Benefit Payments have been satisfied.

3. What amount can I accelerate?

- Your Original Benefit Amount will equal the Death Benefit of the policy (including any benefit provided by a Supplemental Term Insurance Rider on Primary Insured) at the time that we received all requested paperwork properly completed (for the one-time lump sum option it is the date of claim approval). Any acceleration of benefits will reduce your Original Benefit Amount and what is left to be accelerated will be known as the Remaining Benefit Amount. The Original Benefit Amount cannot be changed in any way after acceleration.

4. What are the payment options and what will the different benefit amounts be?

If you are certified as having a Chronic Illness, you will have two options: one-time lump sum and monthly.

The one-time lump sum will terminate the policy.

- The benefit will be the calculated using the Original Benefit Amount or Remaining Benefit Amount (depending on whether you have received a previous benefit under the rider), discounted by a factor based on your age and the interest rate in effect at the time of claim.

The Maximum Monthly Benefit Amount is equal to the lesser of:

- The Original Benefit Amount multiplied by 2%; or
- The monthly equivalent of the Per Diem Limit, as declared by the Internal Revenue Service, that is in effect at the start of any 12-month benefit period. The amount for each month is dependent on the number of days in that month.

The Maximum Monthly Benefit Amount is calculated at the start of each Benefit Period and remains fixed during that Benefit Period. There may be a small variance from month to month if the Maximum Monthly Benefit amount is based on the Per Diem Limit as the number of days in any month will determine the exact amount that can be distributed. You can choose to take less than the Maximum Monthly Benefit Amount, but the remaining portion cannot be added to future payments.

If you are certified as having a Terminal Illness, you will have only one option:

- The terminal illness benefit is a lump sum benefit to exceed no more than 50% of the Original Benefit Amount (Remaining Benefit Amount if you have received a previous benefit under this rider) or $250,000, whichever is less.

Whether certified under Chronic Illness or Terminal Illness, if there is Debt, a portion of the benefit amount will be used to pay down the Debt as provided in your rider.

5. What is the administrative expense fee?

There is no administrative expense fee. There is a cost for the rider as disclosed in your policy.

6. How will accelerations impact my policy and riders?

- The Chronic Illness one-time lump sum will terminate the policy.
- For the Chronic Illness Maximum Monthly Benefit and the Terminal Illness Benefit, any benefit payment will reduce the policy values listed below. The new values can be calculated by multiplying the values in effect immediately prior to a payment by a Reduction Ratio equivalent to (B-A) / B where A is the amount accelerated and B is the Remaining Benefit Amount immediately prior to payment.

The policy's values that are reduced based on the Reduction Ratio described above are:

1. Specified Amount;
2. The death benefit of any Supplemental Term Insurance Rider on Primary Insured, if attached to the Policy;
3. Policy Value;
4. Your Cost Basis in the Policy;

We will send you monthly reports showing impact to some of these values.

Example of Chronic Illness Maximum Monthly Benefit Payment and its impact on policy values:

- Original Benefit Amount is $500,000
- Benefit Period starting 4/14/13
- Maximum Benefit for the month is equal to the lesser of:
  - [2]% x $500,000 = $10,000
  - IRS Per Diem Limit = $[300] x number of days in April (30) = $9000
- Determine Reduction Ratio: (500,000 - 9,000)/500,000 = 0.982
- Apply Reduction Ratio to impacted values:
  - Specified amount = 500,000 x 0.982 = 491,000
  - Account Value = 20,000 x 0.982 = 19,640
  - Remaining Benefit Amount = 500,000 x 0.982 = 491,000

7. What is the premium due once acceleration has begun?
Zero. If net policy values are insufficient to satisfy monthly deductions, we will waive the deductions to keep the policy from defaulting in all months after initial acceleration, even if no additional accelerations are processed. If you take a loan or withdrawal at any time after initial acceleration, even if the policy is not currently being accelerated, the rider and lapse protection will terminate.

8. What is the death benefit after acceleration has begun?
If death occurs after acceleration, we will pay out the Death Benefit at the time of death, reduced for any acceleration payments made after the date of death. The Remaining Benefit Amount is not paid upon death of the Insured.

DEFINITIONS

Activities of Daily Living ("ADLs") The 6 basic functional abilities which measure the Insured's ability for self care and ability to live independently without Substantial Assistance from another individual. They are: Bathing – The Insured's ability to wash himself or herself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower; Continence – The Insured's ability to maintain control of bowel or bladder function, or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag); Dressing – The Insured's ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs; Eating – The Insured's ability to feed himself or herself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously; Toileting – The Insured's ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene; Transferring – The Insured's ability to move into or out of a bed, chair or wheelchair.

Benefit Period A period of time not to exceed twelve consecutive months.
Such period begins on the Monthly Anniversary Day after our receipt of all documentation provided by you necessary to satisfy all Conditions for Eligibility for Benefit Payments. A new Benefit Period will begin no earlier than the end of the current Benefit Period.

Chronically Ill (Chronic Illness) The Insured has been certified, within the preceding 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform (without Substantial Assistance from another individual) at least 2 Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or
2. Requiring Substantial Supervision from another individual to protect the Insured from threats to health and safety due to Severe Cognitive Impairment; AND
3. Needing Services pursuant to a Licensed Health Care Practitioner's Plan of Care as set forth in Written Certification or Written Re-certification, specifying such Services are likely to be needed for the rest of the Insured's life.

If the Licensed Health Care Practitioner certifies that the Insured will need Services for the rest of the Insured's life, the 90 day requirement noted in 1. above is satisfied by the expectation that the Insured will be unable to perform at least 2 Activities of Daily Living prospectively.

Conditions for Eligibility for Benefit Payments

You are eligible to receive an accelerated benefit payment if the Policy and this rider are In Force when all of the following requirements are met:

1. Our receipt and approval of the following documentation provided by you:
   a. Certification of either:
      i. For Chronic Illness, Written Certification or Written Re-certification by a Licensed Health Care Practitioner that the Insured is a Chronically Ill individual; or
      ii. For Terminal Illness, Terminally Ill Certification by a Licensed Health Care Practitioner that the Insured is Terminally Ill.
   b. Our receipt of consent to make such payment, In Writing, of any assignee of record named under the Policy or any irrevocable beneficiary named under the Policy.
2. We complete, at our discretion and expense, a personal interview with, and an assessment of, the Insured, including examination or tests by a Licensed Health Care Practitioner of our choice; and our receipt of copies of any relevant medical records from a health care provider involved in the Insured's care; and
3. The Insured is living at the time all of the above requirements are met.

Cost Basis The aggregate amount of premiums or other consideration you have paid for the Policy, less the aggregate amount you have received under the contract that was not included in your taxable income, and less reductions in values due to benefit payments under this rider as described in the "Impact of Rider Benefits on Policy and Other Riders" provision.

Licensed Health Care Practitioner A physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury, or qualifications to our satisfaction. The Licensed Health Care Practitioner (a) must be acting within the scope of his or her license in the state of licensure when providing Written Certification or Written Re-certification required by this rider; and (b) may not be you, the Insured, or your or the Insured's immediate family.

Plan of Care A written document signed by a Licensed Health Care Practitioner which outlines the individualized medical treatment and non-medical assistance and Services which are prescribed because the Insured suffers from loss of functional capacity or from a Severe Cognitive Impairment. The plan must specify where the care is to be provided; the type, frequency, and duration of all medication, therapy, and Services required. It must also describe the likelihood of improvement or deterioration of the Insured's condition within the next 12 months from the date the Plan of Care was prepared and must also describe the supporting evidence upon which the Licensed Health Care Practitioner has based his or her conclusions and prognosis. Such supporting evidence may include either documents or information relevant to the assessment of loss of functional capacity or to the assessment of Severe Cognitive Impairment, or both.

Per Diem Limit The maximum daily benefit used in determining the Chronic Illness Maximum Monthly Benefit. The Internal Revenue Service establishes this limit annually on January 1st. We will use the limit in effect at the beginning of each Benefit Period for the entire Benefit Period.

Remaining Benefit Amount The Original Benefit Amount less the amount of all Chronic Illness Monthly Benefit Amounts paid and, if applicable, less the Terminal Illness benefit paid divided by the applicable Terminal Illness actuarial discount factor.

Services The necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services needed by a Chronically Ill Insured.

Severe Cognitive Impairment Deterioration or loss in the Insured's intellectual capacity that is:

a. comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
b. measured and confirmed by clinical evidence and standardized tests that reliably measure impairment in the following areas:
    1. the Insured's short-term or long-term memory;
    2. the Insured's orientation as to person (such as who they are), place (such as their location), and time (such as day, month, and year); and
    3. the Insured's deductive or abstract reasoning, including judgment as it relates to safety awareness.

Substantial Assistance Hands-on assistance or the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activities of Daily Living.

Substantial Supervision Continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the Insured from threats to his or her health or safety (such as may result from wandering) due to Severe Cognitive Impairment.

Terminally Ill (Terminal Illness) The Insured's life expectancy is reduced to 12 months or less.

Terminally Ill (Terminal Illness) Certification Before any benefit can be paid for Terminal Illness, you must furnish evidence satisfactory to us. Such evidence must include a certification of the Insured's medical condition from a Licensed Health Care Practitioner. The certification must state that in the Licensed Health Care Practitioner's opinion the Insured's life expectancy has been reduced to 12 months or less.

Written Certification Written documentation required in a form satisfactory to us completed by a Licensed Health Care Practitioner, at your or the Insured's expense, certifying that the Insured is Chronically Ill as defined herein, including a Plan of Care, and specifying that Services are likely to be needed for the rest of the Insured's Life.

Written Re-certification Written Certification that we must receive and approve prior to the start of each Benefit Period following the initial Benefit Period in order for you to be eligible for Chronic Illness Monthly Benefit Amounts in such subsequent Benefit Period, provided all other Conditions for Eligibility for Benefit Payments are met.

I have received and read a copy of this disclosure.

Signed in _____, this _____ day of _____ _____
(state) (month) (year)

_____ _____
Signature of Owner **Signature of Agent/Producer**

_____ _____
Signature of Owner **Signature of Owner**

_____
Signature of Owner